PROVIDENCE
Medical Group
Hood River

Providence Medical Group-Hood River
Orthopedics Center
902 12th St.
Hood River, OR 97031
541-387-1818 | fax 541-387-1301

Appointment date _____

Appointment time _____

Welcome to the Providence Medical Group-Hood River. We welcome you as a patient and thank you for choosing us to participate in your health care.

For your first appointment, please arrive **15 minutes prior to your scheduled appointment to complete registration process.** Please request the last six months of chart notes from your current primary care physician and the last two years of specialty care including labs and X-rays.

It is ideal for you to have been referred by a primary care physician or provider, but not always necessary so please be sure to check with your primary care provider or insurance first. Your primary care physician will receive a full report with recommendations for coordination of care.

We request that you refrain from wearing perfumes or colognes, as we see many patients who are susceptible to allergic reactions to scents.

Please bring the following to your appointment:

- Photo ID
- Medical insurance card
- Completed patient forms
- A referral number from your insurance company, if necessary. Your primary care provider will provide this.

If you need to change your appointment, please give us 48 hours notice. If you have any questions, please contact our office at 541-387-1818.

If you are uninsured, please make time to visit the financial assistance office at Providence Hood River Memorial Hospital (main entrance) to ask about options for help with covering your medical bills.

We look forward to seeing you soon.

For office use:
□ New Patient □ Established Patient
Last seen _____

PROVIDENCE Medical Group Hood River

PATIENT HEALTH HISTORY

PATIENT NAME: _____ **BIRTHDATE**: _____ Sex: M F

CURRENT WEIGHT: _____HEIGHT:_____ PRIMARY CARE PHYSICIAN: _____

MARITAL STATUS: _____ EMPLOYED: _____ FULL TIME / PART TIME

Emergency Contact: _____ Phone: _____

CURRENT MEDICATIONS & DOSAGES

>>>>>>> Include: ASPIRIN & other over-the-counter medications
(Examples: prescription, steroid/cortisone, birth control, vitamins & non-prescription)

Check one or complete below: _____ NONE _____ see separate list I have provided

_____

_____

_____

Have you seen one of our orthopedic providers, in the last three years? ___Yes ___No,
Dr: _____
Is there any chance of current pregnancy? (X-ray concern): _____ _____ _____
(Please update with initials and date) _____ please check if this cannot apply to you.

_____

ALLERGIES >>>>>> ____ No known allergies

Codeine	_____	Latex	____	Tetanus Antitoxin or Serums	_____
Penicillin	_____	Sulfa	____	Any Anesthesia Related Drug	_____
Morphine	_____	Aspirin	____	Drug (name)	_____
Fiberglass	_____	Other	_____ _____	Food (name)	_____

YOUR CURRENT PROBLEM

(Use for today's and future visits)

Today's Date: _____
Problem (indicate left, right or both sides & body part):
_____
Is this Due to an Accident: Motor Vehicle Accident/
Work Comp/ Other:_____/ No Accident
(skip below)
Date Of Injury: _____Time:_____ (Approx.)
Where did it happen? _____
How did it happen? _____
_____
Have you had X-Rays or Studies? _____No ____Yes
If Yes, where: _____
Referring Physician: _____

Today's Date: _____
Problem (indicate left, right or both sides & body part):
_____
Is this Due to an Accident: Motor Vehicle Accident/
Work Comp/ Other:_____/ No Accident
(skip below)
Date Of Injury: _____Time:_____ (Approx.)
Where did it happen? _____
How did it happen:_____
_____
Have you had X-Rays or Studies? _____No ____Yes
If Yes, where: _____
Referring Physician: _____

Medical Record #_____

Only: List anything that you have had in the last 3 years.

YOUR SURGERIES				OTHER HOSPITALIZATIONS		
YEAR	**OPERATION**	**HOSPITAL**	*	**YEAR**	**REASON**	**HOSPITAL**
_____	_____	_____	*	_____	_____	_____
_____	_____	_____	*	_____	_____	_____
_____	_____	_____	*	_____	_____	_____

PLEASE CHECK IF *"YOU"* SUFFER FROM ANY OF THE FOLLOWING:

- ☐ **HIV/AIDS**
- ☐ CANCER
- ☐ DIABETES
- ☐ ALZHEIMER'S
- ☐ PARKINSON'S
- ☐ KIDNEY INFECTION OR DISEASE
- ☐ LIVER DISEASE
- ☐ SEIZURE DISORDER OR EPILEPSY
- ☐ PAIN: BACK/NECK
- ☐ **HEPATITIS, Yellow Jaundice**
- ☐ DIZZINESS OR BLACKOUTS
- ☐ HIATAL HERNIA
- ☐ ULCERS
- ☐ MUSCLE OR NERVE DAMAGE
- ☐ CHRONIC DIARRHEA
- ☐ ANKLE OR LEG SWELLING
- ☐ THROMBOSIS/EMBOLISM
- ☐ BLEEDING TENDENCY
- ☐ **TUBERCULOSIS, Bloody Sputum**
- ☐ CHRONIC COUGH
- ☐ BRONCHITIS
- ☐ EMPHYSEMA
- ☐ ASTHMA
- ☐ SHORTNESS OF BREATH WITH ACTIVITY
- ☐ STROKE OR TIA
- ☐ CHEST PAIN/ANGINA
- ☐ ABNORMAL EKG/RHYTHM
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART ATTACK

☐ **OTHER CONDITION(S)** (*please list):*_____

FAMILY HISTORY	RELATIONSHIP	CHILDREN		
		AGE	**SEX**	**HEALTH STATUS**
ARTHRITIS	_____			
STROKE	_____	_____	_____	_____
CANCER (location)	_____			
DIABETES	_____	_____	_____	_____
HEART DISEASE	_____			
HIGH BLOOD PRSR	_____	_____	_____	_____
KIDNEY PROBLEMS	_____			
LUNG DISEASE	_____	_____	_____	_____
ASTHMA	_____			

HABITS

TOBACCO: ☐ NO ☐ YES FORM /AMOUNT USED: _____ # YRS. USED_____

ALCOHOL: ☐ NO ☐ YES FORM /AMOUNT USED: _____ # YRS. USED_____

RECREATIONAL DRUGS: NO/YES FORM/AMOUNT USED: _____ # YRS. USED_____

DAILY ACTIVITIES

OCCUPATION: ____ working _____retired _____ not employed _____ student _____ child

DESCRIBE YOUR JOB: _____

DESCRIBE YOUR RECREATIONAL ACTIVITIES/ USUAL EXERCISE: _____

_____

Patient Name: _____ Medical Record #_____

Authorization for Release of Medical Records

PROVIDENCE Medical Group Hood River

Patient's Name: _____
First *Middle* *Last*

Date of Birth: ____/____/____ **Social Security Number:** _____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION		
FROM:	Name (Medical Provider holding records): _____ Address: _____	
TO:	Name:	Phone #
	Address:	Fax #

The purpose of the release is: ❑ Diagnostic Evaluation ❑ Reimbursement ☑ Follow-Up Care ❑ Legal ❑ Other

The following information may be released: ☑ Clinical notes (Re: _____)

☑ Laboratory Reports (LAST 2 YEARS) ☑ Immunization Records ☑ Medication Records ☑ X-Ray Reports

☑ Other: EKG'S, PATHOLOGY REPORTS, SPECIAL STUDIES, SPECIALISTS' CONSULTS, HOSPITAL RECORDS INCLUDING ER VISITS, ADMITS, H&P'S, IN PT. CONSULTS, SURGERY/PROCEDURE REPORTS, AND DISCHARGE SUMMARIES (LAST six MONTHS ONLY)

Information may be released for dates of service from SEE ABOVE through SEE ABOVE

This authorization expires six months from the date signed or: _____ (specified expiration date)

I have read the above and fully understand its contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

_____ (Signature of patient or representative)

_____ Relationship (if signed by representative)

_____ Date Signed

_____ Witness (optional)

Driver's License/Identification _____

I do ____/do not ____ specifically consent to transmission of my medical records via a facsimile (fax) machine. Signature Date	I recognize that the information disclosed may contain drug/alcohol information that is protected by Federal and State law. I specifically consent to disclosure of such information Signature Date
I recognize that the information disclosed may contain mental health information that is protected by Federal and State Law. I specifically consent to disclosure of such information Signature Date	I recognize that the information disclosed may contain information regarding sexually transmitted diseases or HIV / AIDS testing information. I specifically consent to disclosure of such information Signature Date

This authorization may be revoked at any time unless prior action has been taken as a result of this form. Records obtained as authorized by this consent for information release will be maintained in accordance with Federal confidentiality regulations (Title 42 of the Federal Register) which prohibits re-disclosure.

Medical Record # _____